DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To:	Physical Therapists Managed Care Plans	**Memorandum No: 05-58 MAA** **Issued: June 30, 2005**
From:	Douglas Porter, Assistant Secretary Medical Assistance Administration (MAA)	**For Information Call:** (800) 562-6188
		Supersedes # Memorandum: **04-88**

Subject: Physical Therapy Program: Fee Schedule Changes

Effective for dates of service on and after July 1, 2005, the Medical Assistance Administration (MAA) will implement:

- The updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2005 relative value units (RVUs);
- A one (1.0) percent vendor rate increase.

Maximum Allowable Fees

MAA is updating the Physical Therapy Program fee schedule with Year 2005 RVUs. The 2005 Washington State Legislature did appropriate a one (1.0) percent vendor rate increase for the 2006 state fiscal year. The maximum allowable fees have been adjusted to reflect these changes.

Attached are updated replacement pages 13–16 for MAA's current *Physical Therapy Program Billing Instructions*.

Bill MAA your usual and customary charge.

Diagnosis Reminder

MAA requires valid and complete ICD-9-CM diagnosis codes. When billing MAA, use the highest level of specificity (4^{th} or 5^{th} digits when applicable) or the entire claim will be denied.

MAA's Provider Issuances

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

Fee Schedule

☞ **Note:** A program unit is based on the CPT® code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes.

Due to its licensing agreement with the American Medical Association, MAA publishes only official, brief CPT code descriptions. To view the full descriptions, please refer to your current CPT book.

Procedure Code	Brief Description	July 1, 2005 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
Tens Application			
64550	Apply neurostimulator	$10.67	$5.45
Muscle Testing (The maximum allowable is for payment in full, regardless of time required.)			
95831	Limb muscle testing, manual	17.26	9.54
95832	Muscle testing manual	14.53	9.77
95833	Body muscle testing, manual	24.53	16.35
95834	Body muscle testing, manual	28.84	20.67
95851	Range of motion measurements	12.04	5.68
95852	Range of motion measurements	8.63	3.86
Modalities			
97010	Hot or cold packs therapy	Bundled	
97012	Mechanical traction therapy	8.86	8.86
97014	Electrical stimulation therapy	8.63	8.63
97016	Vasopneumatic device therapy	8.40	8.40

Procedure Code	Brief Description	July 1, 2005 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
97018	Paraffin bath therapy	3.86	3.86
97020	Microwave therapy	2.95	2.95
97022	Whirlpool therapy	8.86	8.86
97024	Diathermy treatment	3.18	3.18
97026	Infrared therapy	2.95	2.95
97028	Ultraviolet therapy	3.63	3.63
(For the procedures listed below, the therapy provider is required to be in constant attendance.)			
97032	Electrical stimulation	9.54	9.54
97033	Electrical current therapy	12.26	12.26
97034	Contrast bath therapy	8.40	8.40
97035	Ultrasound therapy	7.27	7.27
97036	Hydrotherapy	13.85	13.85
97039	Physical therapy treatment	7.04	7.04
Therapeutic Procedures (Therapy provider is required to be in constant attendance.)			
97110	Therapeutic exercises	16.81	16.81
97112	Neuromuscular re-education	17.71	17.71
97113	Aquatic therapy/exercises	19.30	19.30
97116	Gait training therapy	14.76	14.76
97124	Massage therapy	13.40	13.40
97139	Physical medicine procedure	9.54	9.54
97140	Manual therapy	15.90	15.90
97150	Group therapeutic procedures	10.45	10.45

Procedure Code	Brief Description	July 1, 2005 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
97504	Orthotic training	$18.40	$18.40
97520	Prosthetic training	16.81	16.81
97530	Therapeutic activities	17.71	17.71
97535	Self care mngment training	18.17	18.17
97537	Community/work reintegration	16.35	16.35
97542	Wheelchair mngment training	Not Covered	
97545	Work hardening	Not Covered	
97546	Work hardening add-on	Not Covered	
97597	Active wound care/20 cm or <	29.30	29.30
97598	Active wound care > 20 cm	37.47	37.47
97602	Wound care non-selective	19.53	19.53
97605	Neg press wound tx, < 50 cm	Bundled	Bundled
97606	Neg press wound tx, > 50 cm	Bundled	Bundled
Tests and Measurements			
97001	Pt evaluation	45.65	38.61
97002	Pt re-evaluation	24.30	19.30
97703	Prosthetic checkout	15.44	15.44
97005	Athletic evaluation	Not Covered	
97006	Athletic re-evaluation	Not Covered	
97750	Physical performance test	17.94	17.94
97755	Assistive technology assessment	20.89	20.89
Other Procedures			
97532	Cognitive skills development	Not Covered	
97533	Sensory integration	Not Covered	
97799	Unlisted physical medicine rehabilitation service or procedure	By Report	

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an initial claim within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

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[1] **Delayed Certification**: A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider MUST refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[2] **Retroactive Certification**: An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider MAY refund payment made by the client and then bill MAA for the service.